Appendix I. Technical Specifications of the Advance Care Plan Measure adapted for PCF (Claims-based Measure)

Beginning in PY 2022, the Advance Care Plan (ACP) adapted for Primary Care First (PCF) (claims-based measure), is a Medicare Part B claims-based, process of care measure that CMS calculates. The measure captures the percentage of a practice's attributed Medicare beneficiaries, ages 65 years and older, who have an advance care plan or surrogate decision maker documented in the medical record or who have documented that the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

The PCF ACP measure follows the specifications of the ACP measure used in the Bundled Payments for Care Improvement (BPCI) Advanced model but differs by its use of PCF-attributed beneficiaries and practices. Within PCF, the ACP measure is 1 of 5 Quality Gateway measures for practices in Risk Groups 1 and 2 and 1 of 3 Quality Gateway measures for practices in Risk Groups 3 and 4. To be eligible for a positive Performance-based Adjustment, PCF practices must meet or exceed the 30th percentile of performance among a national benchmark population on the ACP measure in the applicable performance period. Chapter 4 includes additional detail on the PCF quality strategy, including the measures assessed as part of the Quality Gateway for Risk Group 1 and 2 practices and Risk Group 3 and 4 practices and the methods used for establishing benchmarks for each measure. The following describes the process for calculating the ACP measure at the practice level for all Medicare beneficiaries attributed to each PCF practice in a given year.

Step 1: Calculation of the Measure Denominator

CMS calculates the ACP measure annually for all beneficiaries ages 65 years and older who are attributed to the practice for at least 1 quarter during the performance year. Beneficiaries with 0 Physician or Outpatient claims during the performance year are excluded from the practice's denominator.

Step 2: Calculation of the Measure Numerator

To satisfy the numerator criteria of the ACP measure for a given PCF-attributed beneficiary included in the denominator, CMS must observe a Physician or Outpatient claim for the beneficiary with 1 of the qualifying Current Procedural Terminology (CPT) codes and a date of service during the performance year. The qualifying codes for this measure are as follows:

- CPT I codes: 99497 and 99498
- CPT II codes: 1123F and 1124F

Any health care practitioner that is eligible to bill for the service may submit the qualifying claim, regardless of the practitioner's participation in PCF. The qualifying service may also be provided in any health care setting except for the emergency department; claims with emergency

department as the place of service do not satisfy the numerator criteria for the measure. Claims with both CPT II code 1123F or 1124F and an 8P modifier, indicating advance care planning was not documented in the medical record, do not satisfy the ACP numerator criteria.

Step 3: Calculation of the Practice Score

To calculate the ACP measure score for the practice, CMS divides the measure numerator by the measure denominator and multiplies by 100. The resulting score can be interpreted as the percentage of a practice's attributed beneficiaries ages 65 years and older with a numerator-qualifying claim during the performance year.

For more detailed claims guidance, visit the QPP Resource Library and search for the Part B Claims Reporting Quick Start Guide.

Please note that ACP adapted for PCF (claims-based measure) does not have a data completeness factor as part of the measure calculation.